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SCREENINGS AND ASSESSMENTS USED IN THE JUVENILE JUSTICE SYSTEM

Juvenile Mental Health Screenings and Assessments

An overview of screening and assessment instruments used to detect mental health problems in juveniles entering the delinquency system.

Judicial Council of California
Administrative Office of the Courts

Chief Justice Tani Cantil-Sakauye
Chair of the Judicial Council

William C. Vickrey
Administrative Director of the Courts

Ronald G. Overholt
Chief Deputy Director

Center for Families, Children & the Courts Staff

Diane Nunn
Division Director

Charlene Depner, Ph.D.
Assistant Director

Audrey Fancy
Supervising Attorney

Francine Byrne
Supervising Research Analyst

Amy J. Bacharach, Ph.D., Author
Senior Research Analyst

Judicial Council of California
Administrative Office of the Courts
Center for Families, Children & the Courts
455 Golden Gate Avenue, 6th Floor
San Francisco, CA 94102-3688

JUVENILE MENTAL HEALTH SCREENINGS AND ASSESSMENTS

Like their adult criminal justice counterparts, juvenile detention facilities have become the de facto mental health institutions for youth.[1] Up to 70 percent of youth in detention have a mental illness, and at least 20 percent have disorders so severe that their ability to function is impaired.[2] Approximately 60 percent of those with a mental illness also meet the criteria for having a substance abuse disorder, a co-occurring disorder.[3] In a report prepared for the Chief Probation Officers of California (CPOC) and the California Mental Health Directors Association (CMHDA), 18 California counties reported that more than half of their detained populations are either suspected of having or diagnosed with a mental health disorder.[4] In a separate survey of California probation departments, several counties noted that they would like to have the tools to better match juveniles with needed services and to predict potential risks.[5] Screenings and assessments facilitate the appropriate matching.

There are several types of screenings and assessments that detect various risks and needs. Using validated screening and assessment instruments is one part of a broad evidence-based approach to juvenile justice and promotes public safety and positive outcomes for youth.[6] The instruments are also the juvenile justice system's first opportunity to appropriately identify youths' risks and needs in order to make the best decisions regarding detention and treatment. Mental health screenings and assessments may allow some youth to be diverted to mental health services in the community rather than in detention.

This briefing focuses on juvenile mental health screenings and assessments, which help determine both risks and needs related to mental health, substance abuse, and co-occurring disorders. This briefing is one of several in a series of AOC Briefings on topics of interest to judicial officers and court stakeholders, including a detailed overview of assessments used in the juvenile justice system,[7] evidence-based practices,[8] and family-based treatment models.[9]

[1] E. Cohen & J. Pfeifer, *Costs of Incarcerating Youth with Mental Illness. Final Report* (Chief Probation Officers of Cal. & Cal. Mental Health Directors Assn., 2008), *www.cdcr.ca.gov/COMIO/docs/Costs_of_Incarcerating_Youth_with_Mental_Illness.pdf* (as of July 14, 2010).
[2] Nat. Center for Mental Health & Juvenile Justice & Policy Research Assoc., Inc., *Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System* (Off. of Juvenile Justice & Delinquency Prevention, U.S. Dept. of Justice, 2007), *www.ncmhjj.com/Blueprint/default.shtml* (as of Nov. 24, 2010).
[3] *Ibid.*
[4] Cohen & Pfeifer, *supra* note 1.
[5] *Ibid.*
[6] For a discussion on evidence-based practices and programs, see Judicial Council of Cal./Admin. Off. of Cts., *AOC Briefing: Evidence-Based Practices and Programs* (2011), *in press*.
[7] Judicial Council of Cal./Admin. Off. of Cts., *AOC Briefing: Assessments Used in the Juvenile Justice System* (2010), *in press*.
[8] Judicial Council of Cal./Admin. Off. of Cts., *AOC Briefing: Evidence-Based Practices and Programs* (2011), *in press.*
[9] Judicial Council of Cal./Admin. Off. of Cts., *AOC Briefing: Family-Based Treatment Models* (2009), *www.courtinfo.ca.gov/programs/cfcc/pdffiles/AOCBriefApr09Online.pdf* (as of Nov. 24, 2010).

It is important to note that mental health screenings and assessments should be conducted in addition to or in conjunction with other risk/needs screenings and assessments that are conducted, even if other risk/needs instruments include a brief mental health component. The results of all screenings and assessments should ensure that youth not only have the appropriate level of security and supervision, but also that they have access to the services and treatment they need.[10]

Screenings are different from assessments. A screening is a short process to quickly determine risk; an assessment is a comprehensive evaluation of specific risks and needs. Screening and assessment are processes that are distinguished from instruments used in those processes. For example, an assessment is a process that utilizes various assessment instruments, or tools, to facilitate decisionmaking, as well as a clinical interview and other methods to determine risks and needs.

The following sections discuss the differences between screenings and assessments, as well as considerations for adopting and implementing screening and assessment instruments. A brief description of specific instruments is also examined.

Screening Versus Assessment

A screening is part of a triage process that generally occurs at the point of intake into the system. Screening instruments are brief questionnaires that are administered to all youth at point of intake and can be completed by nonclinical staff. The screening tool may be used to make initial decisions regarding a youth's placement and immediate treatment needs, including the need for further evaluation.

An assessment is an in-depth evaluation of a youth's needs, which may include data collection from a variety of sources, including assessment instruments. Assessment instruments are generally longer and more comprehensive than screening tools and may include an evaluation of a youth's risks, strengths, needs, and abilities. Assessments are typically conducted by a licensed clinician because of the training necessary to administer many assessment instruments and to make a diagnosis.

SCREENINGS

A screening can be described as a triage process that generally takes place at intake, in pretrial detention, or upon entering placement.[11] A general screening may determine youths' risk for reoffense and criminogenic needs. A mental health screening is a relatively short process to determine whether a youth is specifically at risk of having mental health problems, is at risk of suicide, or may be a risk to others. A screening generally takes between 10 and 30 minutes and determines whether further evaluation, or an assessment, is needed. A mental health screening should identify substance use, suicidality, anger, mood and affect, any unusual thoughts or beliefs, and impulse control.

[10] Nat. Center for Mental Health & Juvenile Justice & Policy Research Assoc., Inc., *supra* note 2.

[11] T. Grisso & L. A. Underwood, *Screening and Assessing Mental Health and Substance Use Disorders Among Youth in the Juvenile Justice System: A Resource Guide for Practitioners*, (Off. of Juvenile Justice & Delinquency Prevention, U.S. Dept. of Justice, 2004), *www.ncjrs.gov/pdffiles1/ojjdp/204956.pdf* (as of July 14, 2010).

A mental health screening should utilize an instrument that (1) has been developed for juveniles and is standardized; (2) has established evidence for its ability to provide valid and reliable information; and (3) is administered in accordance with its procedures and manual by someone sufficiently trained to use that instrument.[12] Screening instruments vary in format, content, length, and the time required to both administer and score. They may be a "paper-and-pencil" type of instrument or computerized. They may have multiple scales or just one scale. And they may include a wide range of items that take differing times to complete. Screenings can usually be done by nonclinical staff who have been appropriately trained to administer the screening tool.

Juvenile mental health screening instruments should be multidimensional; instruments that focus on only one area are limited in their usefulness.[13] Results of screenings should never be used to make a diagnosis or to make decisions about a juvenile's disposition. A screening provides a snapshot of a juvenile's mental state at a given point in time and should be used only to determine whether a more comprehensive assessment is necessary.[14]

ASSESSMENTS

An assessment is a comprehensive follow-up examination for any needs and problems identified during the screening. Assessments include data collection using standardized, evidence-based assessment instruments, clinical interviewing, and review of past records.[15] Assessments broadly cover clinical needs, educational needs, functional rehabilitation needs, and risk classification. A thorough mental health assessment identifies any psychiatric disorders; substance abuse; problem behaviors, such as anxiety, suicidal tendencies, unusual thoughts, anger, and aggression; intellectual and neurological deficits; family characteristics; and strengths.[16] Thus, those who conduct assessments must have sufficient training to do so, such as clinical license and training in the instruments used.

CONSIDERATIONS WHEN CHOOSING INSTRUMENTS

Both screening and assessment instruments should be evidence based, meaning they have strong validity and reliability verified by rigorous studies; standardized, meaning they are administered to all youth the same way; and culturally relevant and competent, meaning they take into consideration respondents' language, trauma, special needs, and other factors. It is also important that instruments are administered in accordance with the developers' instructions.

An instrument is valid when it accurately measures exactly what it intends to measure. For example, items on an instrument that assesses substance abuse are valid if they are related to

[12] V. Williams, "Procedures and Policies: Good Practice and Appropriate Uses of Screening Results," in *Mental Health Screening Within Juvenile Justice: The Next Frontier* (Nat. Center for Mental Health & Juvenile Justice, 2007), www.ncmhjj.com/publications/default.asp (as of Nov. 24, 2010).
[13] L. McReynolds et al., "Diagnostic Screening with Incarcerated Youths" (2007) 34(6) *Criminal Justice & Behavior* 830–845
[14] Williams, *supra* note 12.
[15] Grisso & Underwood, *supra* note 11.
[16] *Ibid.*

issues dealing with substance abuse rather than issues dealing with, say, IQ. An instrument is reliable when it measures the same thing the same way over time. For example, an individual who scores a certain way on an instrument today should score the same way on that instrument tomorrow or next week for it to be considered to reliably predict what the instrument is measuring. Instruments are deemed valid and reliable after extensive research. The instrument should also have been developed specifically for the population for which the instrument is being used and validated for that population, a process called norming. For example, if an instrument was tested and standardized, or normed, on a group of adult men, that instrument is not appropriate to use with anyone but adult men. Thus, any instruments used with juveniles must have been normed on juveniles.

In addition to being valid, reliable, and standardized, instruments should be culturally relevant, and administrators of instruments should be culturally competent. This means overcoming any barriers in language, cognition, and concepts to understanding culturally related beliefs, values, and attitudes, all of which can affect validity.[17] Training on a specific instrument will detail for which populations that instrument is appropriate.

COMMONLY USED SCREENING AND ASSESSMENT INSTRUMENTS

Many screening and assessment instruments are available. The following are commonly used screening and assessment instruments to identify mental health issues and co-occurring disorders in juveniles. Each is validated and evidence based. The screening instruments discussed are the Massachusetts Youth Screening Instrument–Second Version (MAYSI–2), the Diagnostic Predictive Scale (DPS), and the Child and Adolescent Functional Assessment Scale (CAFAS).

The assessment instruments discussed are the Minnesota Multiphasic Personality Inventory–Adolescent (MMPI–A), the Voice Diagnostic Interview Schedule for Children (V–DISC), and the Millon Adolescent Clinical Inventory (MACI).

A table outlining features of these screening and assessment instruments is included at the back of this document.

MASSACHUSETTES YOUTH SCREENING INSTRUMENT–SECOND VERSION (MAYSI–2)

The Massachusetts Youth Screening Instrument screens for emotional and mental health problems and substance abuse and is one of the most widely used and well-validated screening instruments available. It is being used in more than 42 states and 11 foreign countries.[18]

The MAYSI–2 has 7 scales with a total of 52 questions whose responses indicate the presence of mental health and substance abuse symptoms. The scales are problematic substance use, anger/irritability, depression/anxiety, somatic (physical) problems, suicidality, trauma, and thought disturbances. The scale for thought disturbances has been validated only with boys and

[17] Wen-Shing Tseng, D. l. Matthews & T. S. Elwyn, *Cultural Competence in Forensic Mental Health* (Routledge, 2004), p. 25.
[18] Models for Change, "National Youth Screening & Assessment Project" (2009), *www.modelsforchange.net/directory/16* (as of Nov. 24, 2010).

should not be applied to girls. Each scale has a cutoff score to identify juveniles who may be at risk for each of the scales.

The questions are written at a fifth-grade reading level. The youth simply circles "yes" or "no" for each question. It can be used for both male and female youth ages 12 to 17; separate, gender-specific versions are available.

Mental Health Screening Instrument Examples

1. Massachusetts Youth Screening Instrument-Second Version (MAYSI–2)
2. Diagnostic Predictive Scale (DPS)
3. Child and Adolescent Functional Assessment Scale (CAFAS)

The instrument takes approximately 10 minutes to administer and less than 5 minutes to score and requires no clinical training (it does require in-service training in the use of the instrument). It was designed specifically for use with youth in juvenile justice facilities.[19] Researchers recommend introducing the instrument to the youth using it and obtaining informed consent rather than simply handing over the instrument and allowing the youth to fill it out with no introduction to it.[20]

The instrument is available as either a paper-and-pencil test or on a computer and is available in English and Spanish. The MAYSI–2 is available for use at no cost.

DIAGNOSTIC PREDICTIVE SCALE (DPS)

The Diagnostic Predictive Scale is a short-form screening companion to the Diagnostic Interview Schedule for Children (DISC) assessment instrument, which is based on *DSM–IV* diagnostic criteria and described below.[21] Thus, this instrument is sometimes also referred to as the DISC Predictive Scale. The DPS is a self-reporting instrument that screens for mental health and substance abuse problems and is often used in school settings.

The instrument has up to 17 scales, each with 3 to 15 questions. The questions included in the screening refer to the past year and ask about the frequency of behaviors and feelings related to depression, suicidal ideation, anxiety, alcohol and drug use, and general health problems. The results are automatic and give the youth's probability of meeting diagnostic criteria for a given disorder.

The instrument can be used for male and female youth ages 9 to 18. It is available in English and Spanish and is conducted on a computer, which uses audio to read the questions to the youth, who responds using the keyboard or mouse. The DPS takes approximately 10 to 15 minutes to

[19] Grisso & Underwood, *supra* note 11.
[20] Williams, *supra* note 12.
[21] American Psychiatric Assn., *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., Text Revision (2000). The *DSM–IV* is the standard classification system used by clinicians. It classifies mental health disorders and lists criteria for each disorder.

complete and can be administered by any staff trained on the instrument. Use of the instrument requires permission from the developer and payment of a fee.[22]

CHILD AND ADOLESCENT FUNCTIONAL ASSESSMENT SCALE (CAFAS)

The Child and Adolescent Functional Assessment Scale screening instrument is a multidimensional inventory rating scale. It is used in approximately 30 states and assesses the level of impairment of day-to-day functioning related to emotional, behavioral, psychological, psychiatric, or substance use problems.[23] The instrument has five scales and two subscales. The main scales are role performance, thinking, behavior toward self and others, mood/emotions, and substance abuse. The subscales are basic needs and family/social support. Each scale is measured independently, and the level of impairment is rated as one of the following based on the scale's score: minimal/no disruption, mild, moderate, or severe. The scales are scored separately and then totaled. A higher score is related to greater impairment.

The CAFAS can be used with both male and female youth ages 7 to 17 and has received a favorable gender-based analysis.[24] It consists of 315 items and takes between 10 and 30 minutes to complete. The results of the CAFAS can suggest specific interventions to improve emotional and behavioral aspects of the youth who are screened.[25]

The CAFAS is administered by a rater who is trained in the instrument and is familiar with or well informed about the youth. Rather than "administer" the instrument in a traditional sense, the rater chooses from a list of behavioral descriptions and a score is derived from those choices.

In addition to its primary goal of screening for mental health and substance abuse problems, the CAFAS has been shown to be a good predictor of reoffense.[26] As CAFAS scores increase, so does the risk of reoffending; however, low scores do not guarantee that youth will not reoffend. Use of the CAFAS requires a fee.

MINNESOTA MULTIPHASIC PERSONALITY INVENTORY–ADOLESCENT (MMPI–A)

The Minnesota Multiphasic Personality Inventory–Adolescent is one of the most widely used assessment instruments available to clinicians. The MMPI–A is based on the MMPI–2 for adults and is specially designed for adolescents, adding new items that address adolescent issues and behaviors such as attitudes about school and parents, peer group influence, and eating problems. The instrument contains 478 true-false questions in four scales: validity, clinical, content, and

[22] DISC Development Group, Columbia Univ., *Diagnostic Interview Schedule for Children* (undated), *www.promotementalhealth.org/downloads/DISC%20Brochure.pdf* (as of Nov. 30, 2010).

[23] Monterey County Behavioral Health Children's Services, *Child & Adolescent Functional Assessment Scale (CAFAS) Report of Findings* (2005), *www.mtyhd.org/images/stories/Publications/pdf/BHpdfs/CAFASReport2004.pdf* (as of Dec, 10, 2010).

[24] S. Brumbaugh, J. L. Hardison Walters & L. A. Winterfield, "Suitability of Assessment Instruments for Delinquent Girls" (Girls Study Group, Off. of Juvenile Justice & Delinquency Prevention, U.S. Dept. of Justice, 2009), *www.ncjrs.gov/pdffiles1/ojjdp/226531.pdf* (as of Nov. 30, 2010).

[25] M. K. Smith & C. F. Brun, "An Analysis of Selected Measures of Child Well-Being for Use at School and Community-Based Family Resource Centers" (2006) 85 *Child Welfare* 985–1010.

[26] R. Quist & D. Matshazi, "The Child and Adolescent Functional Assessment Scale (CAFAS): A Dynamic Predictor of Juvenile Recidivism" (2000) 35 *Adolescence* 181–192.

supplementary. The validity scale checks for behaviors such as defensiveness, tendency to exaggerate or underreport, and response consistency. The clinical scale measures psychopathology such as depression, anxiety, schizophrenia, and antisocial behaviors. The content scale measures feelings such as anger and low self-esteem. Finally, the supplementary scale measures issues such as substance use problems, immaturity, and repression.[27] If the clinician or another party is interested only in the clinical scale and certain validity subscales, the instrument can be completed using only the first 350 items.

Mental Health Assessment Instrument Examples

1. Minnesota Multiphasic Personality Inventory-Adolescent (MMPI–A)
2. Voice Diagnostic Interview Schedule for Children (V–DISC)
3. Millon Adolescent Clinical Inventory (MACI).

The MMPI–A is appropriate for male and female youth ages 14 to 18. It has received a favorable gender-based analysis.[28] The assessment instrument takes between 60 and 90 minutes to complete and must be administered by a master's level clinician or a psychologist. It is available in English and Spanish and can be completed with paper and pencil or on a computer. The instrument can also be administered orally for those with visual disabilities.

In addition to its use for assessing mental health needs and risks, researchers have found that specific subscales of the MMPI–A are predictive of higher rates of delinquency in male adolescents. These subscales are psychopathic deviate, schizophrenia, and hypomania.[29] Use of the MMPI–A requires a fee.

VOICE DIAGNOSTIC INTERVIEW SCHEDULE FOR CHILDREN (V–DISC–IV)

The Voice Diagnostic Interview Schedule for Children is a computerized, comprehensive, structured diagnostic interview that measures psychiatric risks of youth in the juvenile justice system and is being used in at least 13 states. This instrument is the full assessment instrument on which the Diagnostic Predictive Scale screening instrument, described earlier, is based. The instrument uses *DSM–IV* criteria to measure symptoms of 36 different psychiatric disorders in the past month. The V–DISC–IV questions are grouped into five domains: anxiety disorders, mood disorders (including suicidality), disruptive behavior disorders, substance abuse disorders, and miscellaneous disorders such as eating disorders.[30] The score indicates level of impairment as absent, probably, or definite.

[27] A. Roberts & K. Bender, "Overcoming Sisyphus: Effective Prediction of Mental Health Disorders and Recidivism Among Delinquents" (2006) 70 *Federal Probation*, 19–28, *http://findarticles.com/p/articles/mi_qa4144/is_200609/ai_n17192049/?tag=content;col* (as of Aug. 30, 2010).

[28] Brumbaugh, Hardison Walters, & Winterfield, *supra* note 24.

[29] R. Archer et al., "MMPI-A Characteristics of Male Adolescents in Juvenile Justice and Clinical Treatment Settings" (2003) 10 *Assessment* 400–410.

[30] The computerized version of the DISC–IV that is not by voice includes a measure for schizophrenia in addition to the measures listed.

The V–DISC–IV was designed for male and female youth ages 9 to 17 and requires a third-grade reading level. The instrument takes 60 to 90 minutes to complete and is a self-administered, structured interview using headphones on a computer, which has been shown to increase the likelihood of honest disclosure.[31] Youth hear questions through headphones while reading them on a computer monitor and respond through the computer keyboard. This method allows them to complete the V–DISC–IV interview regardless of their reading skill level. A follow-up interview is then conducted.

A mental health professional who has been trained in administering the V–DISC–IV must administer and conduct the follow-up interview. No fee is required for use.

MILLON ADOLESCENT CLINICAL INVENTORY (MACI)

The Millon Adolescent Clinical Inventory (MACI) is a self-report questionnaire specifically designed for youth in clinical and correctional settings. It contains 160 true-false questions grouped into five scales: personality, expressed concerns, clinical syndromes, modifying indices, and validity. These scales have several subscales, including anxiety, suicidality, substance use problems, eating disorders, and impulsivity. The personality subscales reflect *DSM–IV* criteria and include scales that can help design treatment plans.

The MACI is for male and female youth ages 13 to 19 and is written at a sixth-grade reading level. The instrument takes between 30 and 45 minutes to complete and score. The scores for all subscales are graphed, making results easy to read and understand.

It can be taken as a paper-and-pencil test or on a computer and is available in English and Spanish. A clinician must administer and score the instrument. Use of the MACI requires a fee.

CONCLUSION

Screening and assessment are important for appropriately matching youth with services and sanctions. The use of standardized, evidence-based screening and assessment instruments is an integral piece of a broad evidence-based approach to juvenile justice. Screenings and assessments for mental health and substance abuse should be one part of a larger evaluation of youth to determine factors such as risk of reoffending and other risks. Although screening is an essential tool for determining which youth need further examination, screening results should never be used to make a diagnosis or any decisions about disposition.

Evidence-based practices are constantly evolving as new research occurs. This briefing describes the most common evidence-based instruments available at the current time. Future studies will undoubtedly support other instruments and practices, and further study is necessary to determine with what instruments and practices California counties have had success.

[31] Off. of Juvenile Justice & Delinquency Prevention, U.S. Dept. of Justice, *Assessing the Mental Health Status of Youth in Juvenile Justice Settings, www.ncjrs.gov/html/ojjdp/202713/page1.html* (as of Aug. 30, 2010).

SCREENING INSTRUMENTS

Screening Instrument	*Age*	*Gender*	*Time to Administer and Score*	*Number of Scales*	*Cost to Use*
Massachusetts Youth Screening Instrument- Second Version (MAYSI–2)	12–17	Male and female	15 minutes	7	No
Diagnostic Predictive Scale (DPS)	9–18	Male and female	10–15 minutes	5	Yes
Child and Adolescent Functional Assessment Scale (CAFAS)	7–17	Male and female	10–30 minutes	5	Yes

ASSESSMENT INSTRUMENTS

Assessment Instrument	*Age*	*Gender*	*Time to Administer and Score*	*Number of Scales*	*Cost to Use*
Minnesota Multiphasic Personality Inventory–Adolescent (MMPI–A)	14–18	Male and female	60–90 minutes	4	Yes
Voice Diagnostic Interview Schedule for Children (V–DISC)	9–17	Male and female	60–90 minutes	5	No
Millon Adolescent Clinical Inventory (MACI)	13–19	Male and female	30–45 minutes	5	Yes

The Administrative Office of the Courts, Center for Families, Children, and the Courts (CFCC), will evaluate California's mental health courts to determine their processes and effectiveness. In California, there are more than 40 mental health courts in 30 counties, including both juvenile and adult mental health courts.

Mental health courts are criminal courts that have a dedicated calendar and judge for offenders with mental illness. Mental health courts apply collaborative justice principles to combine judicial supervision with intensive social and treatment services to offenders in lieu of jail or prison. These collaborative justice principles include a multidisciplinary, nonadversarial team approach with involvement from justice system representatives, mental health providers, and other support systems in the community. Mentally ill offenders are carefully screened for inclusion in mental health courts, with screening and referral occurring as soon as possible after arrest. Each offender who consents to participate receives intensive case management that includes supervision focused on accountability and treatment monitoring.

Evaluation Objectives

The main objectives of this evaluation are to assist and support mental health courts by exploring their progress toward meeting the essential elements of a mental health court[*] and to identify specific aspects of mental health courts that are particularly beneficial. Additional objectives are to develop best practices for dealing with offenders who are mentally ill and to identify model practices for other jurisdictions that are interested in program replication. Few studies exist that show whether mental health courts have long-term impacts. In addition, an objective of this evaluation is to examine long-term effects of mental health courts. A final objective is to determine the cost effectiveness of mental health courts.

Research Questions

This evaluation will focus on both process and outcomes. In addition, this evaluation will attempt to gain insight into the experience of those using the mental health court. With that in mind, the following research questions will be addressed:

Process

1. Who does the mental health court serve (age, gender, diagnosis, eligibility)?
2. How does the mental health court serve its constituents (referral process, types of services [inpx v. outpx, county-provided v. contract-provided, etc.], sanctions and rewards)?
3. How do program models differ among counties?

[*] The Bureau of Justice Assistance compiled consensus among practitioners, policymakers, researchers, and others about what a mental health court is and what it should be. This consensus resulted in 10 essential elements of mental health court design and implementation, which can be found at www.ojp.usdoj.gov/BJA/pdf/MHC_Essential_Elements.pdf.

4. What is the difference in case processing between the mental health court and a traditional criminal court?
5. What are courts doing to adhere to the 10 essential elements of a mental health court?
6. What are cost-effective practices that the mental health court uses?

Outcomes

1. What is the impact of mental health courts on recidivism (number of arrests)?
2. What is the impact of mental health courts on participants' mental health symptoms?
3. What is the impact of mental health courts on participants' overall functioning (determined by such things as housing, employment, supportive relationships)?
4. What are the costs and benefits of mental health courts?

Evaluation Analysis Methods

To answer the research questions, both quantitative and qualitative data will be collected via surveys, interviews, and focus groups, discussed in the next section. The surveys will be distributed to all California mental health courts and the results will be used to help determine which courts will be selected to participate in an in-depth study. The in-depth study will be conducted in 6 selected courts (3 juvenile and 3 adult) and will include process, outcomes, and cost-benefit analysis. Outcomes will be measured in those selected courts using a pre-post design by comparing participants' recidivism rates, mental health symptoms, and overall functioning before entering the mental health court program to those variables at 3 points after leaving the mental health court program: 1 year, 2 years, and 3 years. Researchers will review court and probation and hospital records (pending HIPAA waiver) of all mental health court participants between June of 2005 and June of 2010 in 6 specific courts and will ascertain differences between the times of up to 2 years before participating and up to 3 years after participating. The cost-benefit portion of this evaluation will be conducted separately and will entail analyses of responses to questions that were used to study costs and benefits of drug courts.

Specific questions to determine process (not exhaustive):

1. What are the eligibility criteria for participants?
2. On average, how many court users are eligible for the program annually? How many of those enter the program?
3. What are the reasons why eligible court users are not accepted to the program?
4. What are the reasons for declining to participate?
5. What diagnoses do participants have? Any dual diagnoses? What diagnoses do eligible nonparticipants have?
6. What are participant demographics (e.g., age, gender, etc.)? What are the demographics of those who are eligible but do not enter the program (if available)?
7. What are the charges and criminal history of participants? Eligible nonparticipants?

8. How are participants referred to the mental health court? What is the screening and assessment process?
9. What is the time period between arrest and screening? Between screening and acceptance? Between acceptance and case termination?
10. What are reasons for termination? How many graduate?
11. What is the attendance rate for court team members at staff meetings? Review hearings?
12. How many hours of mental health court-related training do court team members receive? Judges?
13. How often is the list of treatment/service providers reviewed or added to?
14. What is the average caseload for caseworkers? Others?
15. What specific services does the program offer? Are the services provided by the county directly or through a contract? *(all that apply grid?)*
16. How often are services mandated and for how long?
17. How often are participants required to attend court? Contact probation or parole?
18. What are the attendance rates for required court appearances? Treatments? Other required appearances?
19. What specific rewards and sanctions does the program offer? What is needed to receive a reward or sanction?
20. What is the average number of sanctions that each participant receives? For what reasons?
21. What is the average number of rewards that each participant receives? For what reasons?
22. What kind of exit/discharge planning do participants receive?
23. How do court team members feel about the process and effectiveness of the mental health court (Satisfaction levels, etc.)?
24. How do court users feel about the process and effectiveness of the mental health court?
25. How is court funded?

Specific questions to determine outcomes (not exhaustive):

1. What was the difference in arrest rates between the 2 years preceding participation in the mental health court and the 2 years following participation?
2. How many incarcerations did participants have throughout the study period?
3. What were the reasons for arrests and incarcerations? Are there any differences in types of charges between the 2 time periods?
4. How many days did participants spend in jail or prison for new crimes during the study period? For sanctions or technical violations?
5. How many hospitalizations did participants have during the study period? How long was each one? What were participant's symptoms that precipitated hospitalization (if availalable)?
6. How many emergency room visits did participants have during the study period? What kind of treatment did they receive for each? What were participant's symptoms that precipitated visit?

7. What was participants' housing status throughout study period?
8. What was participants' employment status throughout study period?
9. What was participants' family and other close relationships like throughout study period?
10. How often did participants attend treatment throughout the study period?
11. How often did participants comply with medication directives (self-report, anecdotal)?

Specific questions to determine costs and benefits (not exhaustive):

1. What are the total criminal justice system costs invested in the mental health court?
2. What are the costs for each agency involved in the mental health court?
3. What are the costs and benefits associated with the mental health court?
4. What are the benefits of each agency?
5. What are cost-effective practices of the mental health court?
6. Which expenditures provide taxpayers with the best return on their money?

Data Collection Methods

This evaluation will use several data collection methods from various sources to address the research questions. Surveys will be conducted in all mental health courts in California. The surveys will be used to select 6 mental health courts—3 adult and 3 juvenile—that have the appropriate capacity and history to participate. An in-depth study, including qualitative and outcome data, will then be conducted in the 6 mental health courts. These six courts will be selected by convenience based on the length of time in operation and the ability of data to be derived. This in-depth approach will include interviews, focus groups, court observation, and file review to compare recidivism rates and other variables of mental health court participants before participating in the mental health court and after.

Surveys

All California mental health courts will be identified by CFCC staff. The researchers will distribute one survey per mental health court team in California, which typically includes a judge, district attorney, defense attorney, probation officer, court coordinator, and treatment provider. The survey will be designed to be filled out by the court coordinator with input as necessary from each of the other court team members. The survey will ask process questions noted above.

Interviews

Researchers will conduct one to three interviews with each member of all 6 court teams (3 juvenile and 3 adult). These interviews will help to ascertain court team members' experiences and thoughts about specific aspects of the mental health court process.

The questions asked in the interviews will pertain to court processes as well as interviewees' thoughts on how the court works.

Focus Groups

Researchers will conduct one to three focus groups with mental health court participants and their families, as available, in each of the 6 courts. These focus groups will help to ascertain participants' experiences and thoughts about the mental health court process.

Court Observation/Site Visits

Researchers will visit the 6 court sites selected at least once to observe the mental health court in each site. Researchers will develop a form to note details about the court visit such as the location of the court, the number of court team members involved, the number of participants present, etc.

File Review

Researchers will collect individual-level outcome data for all mental health court participants in the 6 courts between June of 2005 and June of 2010. These data will include individual participants' court and probation records to determine criminal history and probation compliance, including arrests and incarceration dates as well as treatment utilization. Pending confidentiality waivers, researchers will collect Department of Public Health (DPH) data related to participants' mental health history such as hospitalizations, symptoms, and medications.

Cost-Benefit Analysis

A cost-benefit analysis of mental health courts will also be conducted using methodology developed by the Drug Court Cost Study.